DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Form Approved
OMB No. 0938-0614

REQUEST FOR RECONSIDERATION OF PART A HEALTH INSURANCE BENEFITS

INSTRUCTIONS: *Please type or print firmly.* Leave the block empty if you cannot answer it. Take or mail the WHOLE form to your Social Security office which will be glad to help you. Please read the statement on the reverse side of page 2.

1 BENEFICIARY'S NAME

2 HEALTH INSURANCE CLAIM NUMBER

3 REPRESENTATIVE'S NAME IF APPLICABLE
(☐ RELATIVE ☐ ATTORNEY ☐ OTHER PERSON) ☐ PROVIDER FILING

4. PLEASE ATTACH A COPY OF THE NOTICE(S) YOU RECEIVED ABOUT YOUR CLAIM TO THIS FORM.

5 THIS CLAIM IS FOR
☐ INPATIENT HOSPITAL ☐ SKILLED NURSING FACILITY (SNF) ☐ HEALTH MAINTENANCE ORGANIZATION (HMO)
☐ EMERGENCY HOSPITAL ☐ HOME HEALTH AGENCY (HHA)

6 NAME AND ADDRESS OF PROVIDER (*Hospital, SNF, HHA, HMO*)	CITY AND STATE	PROVIDER NUMBER
7 NAME OF INTERMEDIARY	CITY AND STATE	INTERMEDIARY NUMBER
8 DATE OF ADMISSON OR START OF SERVICES	9 DATE(S) OF THE NOTICE(S) YOU RECEIVED	

10 I DO NOT AGREE WITH THE DETERMINATION ON MY CLAIM. PLEASE RECONSIDER MY CLAIM BECAUSE

11 YOU MUST OBTAIN ANY EVIDENCE (*For example, a letter from a doctor*) YOU WISH TO SUBMIT

☐ I HAVE ATTACHED THE FOLLOWING EVIDENCE

☐ I WILL SEND THIS EVIDENCE WITHIN 10 DAYS

☐ I HAVE NO ADDITIONAL EVIDENCE OR OTHER INFORMATION TO SUBMIT WITH MY CLAIM

12 IS THIS REQUEST FILED WITHIN 60 DAYS OF THE DATE OF YOUR NOTICE?
☐ YES ☐ NO
IF YOU CHECKED 'NO' ATTACH AN EXPLANATION OF THE REASON FOR THE DELAY TO THIS FORM

13 ONLY ONE SIGNATURE IS NEEDED. THIS FORM IS SIGNED BY
☐ BENEFICIARY ☐ REPRESENTATIVE ☐ PROVIDER REP

SIGN HERE ▶

14 STREET ADDRESS

CITY, STATE, ZIP CODE

TELEPHONE | DATE

15 If this request is signed by mark (X), TWO WITNESSES who know the person requesting reconsideration must sign in the space provided on the reverse side of this page of the form.

DO NOT FILL IN BELOW THIS LINE—FOR SOCIAL SECURITY USE —THANK YOU

16 ROUTING
☐ INTERMEDIARY
☐ HCFA RO-MEDICARE
☐ BSS ODR

17 ADDITIONAL INFORMATION

18 SSA OR INTERMEDIARY DATE STAMP

FORM **HCFA-2649** (8-79)
DESTROY PRIOR EDITIONS

BENEFICIARY